		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027532

Facility Name: ManorCare at Normal

Address: 510 Broadway (Number) Normal (City) 61761 (Zip Code)

County: McLean

Telephone Number: (309) 452-4406 **Fax #** (309) 454-7908

IDPA ID Number: 520886946006

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code		X	Corporation		Other		
			"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/02 to 05/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice-President Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,785	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	467	1,407	7,845	9,719	8
9	SNF/PED					9
10	ICF	10,263	13,796	438	24,497	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,730	15,203	8,283	34,216	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.00%

D. How many bed-hold days during this year were paid by Public Aid?
55 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 6,706

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/03 Fiscal Year: 05/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ManorCare at Normal # 0027532 **Report Period Beginning:** 06/01/02 **Ending:** 05/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	178,749	17,590	18,075	214,414	1,586	216,000		216,000			1
2	Food Purchase		155,178		155,178		155,178	(5,685)	149,493			2
3	Housekeeping	110,024	19,063	1,180	130,267		130,267		130,267			3
4	Laundry	22,227	17,197	434	39,858		39,858		39,858			4
5	Heat and Other Utilities			90,123	90,123	6,463	96,586	(681)	95,905			5
6	Maintenance	36,882	12,868	54,259	104,009		104,009		104,009			6
7	Other (specify):* Med Waste			1,202	1,202		1,202		1,202			7
8	**TOTAL General Services**	347,882	221,896	165,273	735,051	8,049	743,100	(6,366)	736,734			8
	B. Health Care and Programs											
9	Medical Director			18,395	18,395		18,395		18,395			9
10	Nursing and Medical Records	1,574,435	158,706	22,727	1,755,868	27,522	1,783,390	(47)	1,783,343			10
10a	Therapy	256,962	6,548	8,931	272,441		272,441		272,441			10a
11	Activities	80,265	4,116	2,331	86,712		86,712		86,712			11
12	Social Services	69,534	50	1,412	70,996		70,996		70,996			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,981,196	169,420	53,796	2,204,412	27,522	2,231,934	(47)	2,231,887			16
	C. General Administration											
17	Administrative	74,392		297,831	372,223	(143,965)	228,258		228,258			17
18	Directors Fees											18
19	Professional Services			4,422	4,422	(884)	3,538	(3,538)				19
20	Dues, Fees, Subscriptions & Promotions			67,820	67,820		67,820	(46,062)	21,758			20
21	Clerical & General Office Expenses	118,718	37,519	198,814	355,051	884	355,935	(185,362)	170,573			21
22	Employee Benefits & Payroll Taxes			503,340	503,340	49,508	552,848		552,848			22
23	Inservice Training & Education			2,419	2,419		2,419		2,419			23
24	Travel and Seminar			17,159	17,159		17,159		17,159			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			94,666	94,666		94,666		94,666			26
27	Other (specify):*			23	23		23	(23)				27
28	**TOTAL General Administration**	193,110	37,519	1,186,494	1,417,123	(94,457)	1,322,666	(234,985)	1,087,681			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,522,188	428,835	1,405,563	4,356,586	(58,886)	4,297,700	(241,398)	4,056,302			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ManorCare at Normal #0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			280,006	280,006	31,304	311,310		311,310			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,587	29,587	27,582	57,169		57,169			32
33	Real Estate Taxes			60,358	60,358		60,358	14,541	74,899			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,449	16,449		16,449		16,449			35
36	Other (specify):*											36
37	**TOTAL Ownership**			386,400	386,400	58,886	445,286	14,541	459,827			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		217,269	2,759	220,028		220,028		220,028			39
40	Barber and Beauty Shops			11,976	11,976		11,976		11,976			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,678	59,678		59,678		59,678			42
43	Other (specify):*		23,066		23,066		23,066		23,066			43
44	**TOTAL Special Cost Centers**		240,335	74,413	314,748		314,748		314,748			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,522,188	669,170	1,866,376	5,057,734		5,057,734	(226,857)	4,830,877			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,685)	2		4
5	Telephone, TV & Radio in Resident Rooms	(681)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(9)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,476)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(47)	10		16
17	Non-Care Related Fees	(2,237)	21		17
18	Fines and Penalties	(4,615)	21		18
19	Entertainment				19
20	Contributions	(1,245)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,538)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(175,780)	21		24
25	Fund Raising, Advertising and Promotional	(46,062)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	14,541	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(23)	27		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (226,857)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (226,857)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ManorCare at Normal

ID# **0027532**

Report Period Beginning: **06/01/02**

Ending: **05/31/03**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Personal Purchases	$ (23)	27	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(23)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ManorCare at Normal # 0027532 **Report Period Beginning:** 06/01/02 **Ending:** 05/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,685)	0	0	0	0	0	0	0	0	0	0	(5,685)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(681)	0	0	0	0	0	0	0	0	0	0	(681)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,366)	0	0	0	0	0	0	0	0	0	0	(6,366)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(47)	0	0	0	0	0	0	0	0	0	0	(47)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(47)	0	0	0	0	0	0	0	0	0	0	(47)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,538)	0	0	0	0	0	0	0	0	0	0	(3,538)	19
20	Fees, Subscriptions & Promotions	(46,062)	0	0	0	0	0	0	0	0	0	0	(46,062)	20
21	Clerical & General Office Expenses	(185,362)	0	0	0	0	0	0	0	0	0	0	(185,362)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(23)	0	0	0	0	0	0	0	0	0	0	(23)	27
28	**TOTAL General Administration**	(234,985)	0	0	0	0	0	0	0	0	0	0	(234,985)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(241,398)	0	0	0	0	0	0	0	0	0	0	(241,398)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ManorCare at Normal # 0027532 **Report Period Beginning:** 06/01/02 **Ending:** 05/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	14,541	0	0	0	0	0	0	0	0	0	0	14,541	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	14,541	0	0	0	0	0	0	0	0	0	0	14,541	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(226,857)	0	0	0	0	0	0	0	0	0	0	(226,857)	45

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O Cost Report)	Toledo,OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 297,831	HCR Manor Care,Inc.	100.00%	$ 297,831	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	8,779	Heartland Management Services	100.00%	8,779		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 306,610			$ 306,610	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH. 43604
Phone Number: (419)252-5500
Fax Number: (419)254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac.	$	$	4,627,197	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac.	920,912	536,824	4,627,197	1,586	2
3	5	Utilities - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac.	112,862		4,627,197	229	3
4	5	Utilities - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac.	3,618,915		4,627,197	6,234	4
5	10	Nursing - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac.	11,131,912	7,408,777	4,627,197	22,625	5
6	10	Nursing - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac.	2,842,925	1,812,855	4,627,197	4,897	6
7	17	General & Admin - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac.	19,326,083	15,188,841	4,627,197	39,280	7
8	17	General & Admin - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac.	66,522,981	38,146,902	4,627,197	114,585	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac.	2,749,439		4,627,197	5,588	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac.	25,498,075		4,627,197	43,920	10
11	30	Depreciation - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac.	148,355		4,627,197	302	11
12	30	Depreciation - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac.	17,998,306		4,627,197	31,002	12
13										13
14	32	Interest				7,352,132			27,582	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 158,222,897	$ 63,094,199		$ 297,831	25

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub Debentures		X	Facility			$ 684,665	$ 684,665			$ 27,582	1
2	Bank of America						983,699				21,902	2
3	(Note was paid off during current year)											3
4	National City Bank							983,699			7,685	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,668,364	$ 1,668,364			$ 57,169	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,668,364	$ 1,668,364			$ 57,169	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number ManorCare at Normal # 0027532 **Report Period Beginning:** 06/01/02 **Ending:** 05/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	45,817	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	60,358	2
3. Under or (over) accrual (line 2 minus line 1).	$	14,541	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	60,358	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	74,899	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	36,800	8
1999	36,282	9
2000	37,569	10
2001	41,693	11
2002	60,358	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ManorCare at Normal COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0027532

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28-479-008	See Attached	$ 20,119.36	$ 20,119.36
2.	14-28-479-008	See Attached	$ 21,732.39	$ 21,732.39
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 41,851.75	$ 41,851.75

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,079 B. General Construction Type: Exterior Masonary Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1971	$ 58,339	1
2			1993 & 2001	115,287	2
3	TOTALS			$ 173,626	3

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90		1971	1962	$ 506,817	$ 69,585		$ 69,585	$	$ 1,056,712	4
5	9			1994	497,564						5
6	10			2001	588,325						6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					139,391		139,391		1,395,812	9
10				1979	60,522						10
11				1980	317,478						11
12				1981	50,351						12
13				1982	21,867						13
14				1984	16,946						14
15				1985	26,268						15
16				1986	18,155						16
17				1987	42,286						17
18				1988	207,264						18
19				1989	134,621						19
20				1990	46,332						20
21				1991	15,386						21
22				1992	57,357						22
23				1993	44,829						23
24				1994	137,130						24
25				1995	72,481						25
26	RENOVATIONS-PATIENT ROOMS			1996	22,684						26
27	CARPET/TILE & INSTALLATION			1996	4,392						27
28	CAPITALIZED LABOR			1996	7,272						28
29	WALLVINYL/DRYWALL			1996	5,194						29
30	SIGNS/BOARDS			1996	1,730						30
31	INSTALL GRID/PANELS			1996	4,402						31
32	CONCRETE WALK/RAMP			1996	2,850						32
33	CABINETS			1996	1,087						33
34	CARPETING			1996	9,845						34
35	ROOFING			1996	24,474						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ELECTRICAL/LIGHTING	1996	$ 2,159	$		$	$	$	37
38	WALLCOVERINGS	1996	5,910						38
39	SIGNS/CORNERGUARDS/CHAIR RAIL	1996	2,433						39
40	INSTALL SHOWER TILE	1996	2,656						40
41	REPAIR COMPRESSOR	1996	900						41
42	CONCRETE WALK	1996	1,053						42
43	PAINTING & DECORATING	1997	15,688						43
44	ROOF REPLACEMENT	1997	3,345						44
45	WALLCOVERINGS	1997	1,788						45
46	TILE & INSTALLATION	1997	2,686						46
47	RETIREMENTS	1987	(29,830)						47
48	RETIREMENTS	1992	(3,110)						48
49	CARPET	1997	1,547						49
50	INSTALL COMPRESSOR	1997	2,583						50
51	ROOF WORK	1997	51,370						51
52	WALK-IN COOLER/FREEZER	1997	9,466						52
53	ALLOC. FAC. PLAN	1997	2,758						53
54	PLUMBING/BATHROOM WORK	1997	1,226						54
55	ELECTRICAL	1997	2,416						55
56	FINISH/STUD	1998	4,865						56
57	PAINTING/WALLCOVERINGS	1998	8,175						57
58	CARPETING	1998	6,460						58
59	PLUMBING	1998	1,456						59
60	ROOFING	1998	2,170						60
61	DOORS/WINDOWS/CASEWORK	1998	9,884						61
62	ELECTRICAL	1998	5,360						62
63	FLOORING/CEILING/COVE BASE	1998	13,283						63
64	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	1,298						64
65	CORPORATE OVERHEAD-PATIENT ROOMS	1998	1,702						65
66	FURNISH & INSTALL STEEL DOORS	1998	2,439						66
67	MILLWORK	1998	1,166						67
68	INSTALL DUCTS	1998	327						68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,081,538	$ 208,976		$ 208,976	$	$ 2,452,524	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,081,538	$ 208,976		$ 208,976	$	$ 2,452,524	1
2	REWORK FIRE/SMOKE DAMPERS	1998	632						2
3	RENOVATE PATIENT ROOMS	1998	5,233						3
4	WALKWAY	1998	7,267						4
5	ELECTRICAL	1998	8,111						5
6	ROOFING	1998	8,485						6
7	SIGNAGE	1998	13,529						7
8	DOORS/WINDOWS	1998	1,773						8
9	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	2,507						9
10	MASONRY	1998	3,700						10
11	PAINTING/WALLCOVER	1998	251						11
12	FLOORING	1998	458						12
13	RENOVATE PATIENT ROOMS	1998	(2,520)						13
14	GAZEBO	1998	2,495						14
15	FLOORS	1999	2,990						15
16	DOORS	1999	18,097						16
17	FENCING	1999	4,343						17
18	SIDEWALK	1999	3,719						18
19	FIRE SPRINKLER	1999	6,270						19
20	WATER HEATER	1999	7,717						20
21	FLOORS	2000	830						21
22	DOORS	2000	11,081						22
23	RENOVATION-ARCADIA ADDTN	2000	5,000						23
24	CONCRETE	2000	1,685						24
25	CARPENTRY	2000	3,179						25
26	DRYWALL / FINISHES	2000	15,397						26
27	CEILING / FLOORING	2000	5,680						27
28	CARPETING & PADS	2000	7,167						28
29	PAINTING	2000	28,868						29
30	WALLCOVERING	2000	7,060						30
31	ELECTRICAL	2000	12,505						31
32	GENERAL OVERHEAD & MISC-ARCADIA ADDTN	2000	25,528						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,300,575	$ 208,976		$ 208,976	$	$ 2,452,524	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,300,575	$ 208,976		$ 208,976	$	$ 2,452,524	1
2	INTEREST ON CONSTRUCTION-ARCADIA ADDITION	2000	5,447						2
3	OVERHEAD COST-ARCADIA ADDITION	2000	43,193						3
4	WATER HEATER	2001	9,350						4
5	8 REPLACEMENT WINDOWS	2001	5,812						5
6	MIXING VALVE	2001	3,397						6
7	CARPET & VWC	2001	24,531						7
8	SOIL & CONCRETE TESTING	2001	2,905						8
9	WATER & SEWER, PERMIT FEES	2001	14,582						9
10	SITEWORK	2001	74,254						10
11	LANDSCAPING	2001	2,270						11
12	ADDITIONAL COST SITEWORK	2001	371						12
13	FLOORING BY GREASE TRAP	2002	753						13
14	FLOORING	2002	5,415						14
15	ADDITIONAL ARCHITECTURE ENG.	2002	65						15
16	ARCHITECTURE ENGINEERING	2002	350						16
17	ARCHITECTURE ENGINEERING	2002	2,993						17
18	FRONT HALL & OFFICE WALLS/FLOORS	2002	7,395						18
19	FRONT HALL & OFFICE WALLS/FLOORS	2002	39,302						19
20	FRONT HALL & OFFICE WALLS/FLOORS	2002	13,311						20
21	DIETARY HVAC	2002	82,214						21
22	SMOKE SHELTER	2002	3,540						22
23	ALUMINUM SHELTER	2002	5,225						23
24	SIDEWALK	2002	2,375						24
25	FENCE	2002	975						25
26	CR5/31/99 AUDIT ADJ - CAPITAL	1996	(7,272)	(364)		(364)		(2,636)	26
27	CR5/31/99 AUDIT ADJ - CAPITAL	1997	(2,758)	(138)		(138)		(747)	27
28	CR5/31/99 AUDIT ADJ - CAPITAL	1998	(1,702)	(85)		(85)		(426)	28
29	RETROACTIVE ADDITION	2002	(10)						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,638,858	$ 208,389		$ 208,389	$	$ 2,448,715	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 798,418	$ 71,617	$ 71,617	$		$ 541,618	71
72	Current Year Purchases	166,197						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			31,304	31,304			74
75	TOTALS	$ 964,615	$ 71,617	$ 102,921	$ 31,304		$ 541,618	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,777,099	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 280,006	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 311,310	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 31,304	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,990,333	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 16,449 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A	3447	hrs	$ 86,185	126	$ 3,158	$ 1,769	3,573	$ 91,112	1
2	Licensed Speech and Language Development Therapist	10A	1504	hrs	37,593	42	1,040	42	1,546	38,675	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A	5327	hrs	133,184	189	4,733	4,737	5,516	142,654	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				217,269		217,269	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): P/S Lab	39					2,759			2,759	13
14	TOTAL				$ 256,962	357	$ 11,690	$ 223,817	10,635	$ 492,469	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number ManorCare at Normal # 0027532 **Report Period Beginning:** 06/01/02 **Ending:** 05/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (14,894)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (226,495))	741,182		3
4	Supply Inventory (priced at)	12,516		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,891		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 741,695	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	173,626		13
14	Buildings, at Historical Cost	3,638,858		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	964,615		16
17	Accumulated Depreciation (book methods)	(2,990,333)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	179,041		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,965,807	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,707,502	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 43,925	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	195,612		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,358		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	50,005		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 349,900	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	983,699		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	(15,278)		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 968,421	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,318,321	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,389,181	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,707,502	$	48

***(See instructions.)**

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 996,297	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 996,297	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	583,400	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 583,400	17
	B. Transfers (Itemize):		
18	**Change In Interdivision**	(190,516)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (190,516)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,389,181	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,953,609	1
2	Discounts and Allowances for all Levels	(1,707,208)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,246,401	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,125,082	6
7	Oxygen	(366)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,124,716	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,791	12
13	Barber and Beauty Care	14,014	13
14	Non-Patient Meals	2,894	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	200,089	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,669	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	9,069	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 266,526	23
	D. Non-Operating Revenue		
24	Contributions	1,245	24
25	Interest and Other Investment Income***	2,237	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,482	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Puchase Discounts	9	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,641,134	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	735,051	31
32	Health Care	2,204,412	32
33	General Administration	1,417,123	33
	B. Capital Expense		
34	Ownership	386,400	34
	C. Ancillary Expense		
35	Special Cost Centers	314,748	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,057,734	40
41	**Income before Income Taxes (line 30 minus line 40)****	583,400	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 583,400	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,937	2,084	$ 52,753	$ 25.31	1
2	Assistant Director of Nursing	3,474	3,739	73,402	19.63	2
3	Registered Nurses	2,851	3,068	67,448	21.98	3
4	Licensed Practical Nurses	28,416	30,580	531,533	17.38	4
5	Nurse Aides & Orderlies	75,403	81,145	828,623	10.21	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	9,584	10,092	255,992	25.37	7
8	Rehab/Therapy Aides	47	49	970	19.80	8
9	Activity Director	7,800	8,286	80,265	9.69	9
10	Activity Assistants					10
11	Social Service Workers	3,963	4,189	69,534	16.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,953	20,085	178,749	8.90	15
16	Dishwashers					16
17	Maintenance Workers	2,067	2,194	36,882	16.81	17
18	Housekeepers	12,373	13,119	110,024	8.39	18
19	Laundry	2,777	2,942	22,227	7.56	19
20	Administrator	2,899	2,080	74,392	35.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,745	9,537	118,718	12.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,189	2,317	20,676	8.92	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	183,478	195,506	$ 2,522,188 *	$ 12.90	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,395	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,413	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,808		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joe Trainor	Administrator	0	$ 74,392
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,392

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 297,831
TOTAL (agree to Schedule V, line 17, col. 3)	$ 297,831
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees		$ 3,538
Grantly Payne & Assoc.	Spec. Consul.	884
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 4,422

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 105,369
Unemployment Compensation Insurance	27,873
FICA Taxes	178,900
Employee Health Insurance	179,404
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K / SMSP Match	5,326
Other Employee Benefits	1,535
Employee Vaccinations	123
Employee Uniforms	4,810
Payroll Overhead Allocated	
Home Office Allocation	49,508
TOTAL (agree to Schedule V, line 22, col.8)	$ 552,848

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,556
Advertising: Employee Recruitment	14,437
Health Care Worker Background Check	2,013
(Indicate # of checks performed 100.7)	
Dues & Subscriptions	749
Association Dues	4,671
Advertising	44,247
Public Relations	147
Less: Non-allowable Assoc. Dues	(1,668)
Less: Public Relations Expense	(147)
Non-allowable advertising	(44,247)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,758

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	17,159
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,159

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ManorCare at Normal # 0027532 Report Period Beginning: 06/01/02 Ending: 05/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $4,671**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes $1,668**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,850** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,678**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,894**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.